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IN THE SUPREME COURT

of the

UNITED STATES

October Term 1985

CHIROPRACTORS, JAMES A. LEONE, et al.,
Petitioners,

vs.

PIERCE COUNTY MEDICAL BUREAU, et. al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

Whether Section 1 of the Sherman Act prohibits health service corporations formed by medical doctors from excluding licensed competing health professionals who do not have a medical or osteopathic degree.

Whether Section 1 of the Sherman Act prohibits health service corporations formed by medical doctors from excluding licensed competing health professionals who do not have a medical or osteopathic license from participating in prepaid plans offered by such corporations.

Whether Section 1 of the Sherman Act prohibits health service corporations from refusing to pay beneficiaries for covered dysfunctions based upon the health license of the health professional offering the treatment.

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Applicable statute:

RCW 48.44.010(3) ..... App. IX

NO. 83-845

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The petitioners James A. Leone, et al., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit entered in this proceeding on July 16, 1985. A full list of the parties to this ostion is set out in the appendix.

OPINION BELOW

The opinion of the Court of Appeals is an unreported opinion. A copy of that opinion appears in the appendix. No written opinion was rendered by the District Court of Western Washington (Tacoma). A transcript of his oral opinion appears in the appendix.

JURISDICTION

The judgment of the Court of Appeals for the Ninth Circuit was entered on July 16, 1985 and its decree was entered on August 8, 1985. This petition for certiorari was filed within 90 days of that date. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

Whether Section 1 of the Sherman Act prohibits health service corporations formed by medical doctors from excluding licensed competing health professionals who do not have a medical or osteopathic degree.

Whether Section 1 of the Sherman Act prohibits health service corporations formed by medical doctors from excluding licensed competing health professionals who do not have a medical or osteopathic license from participating in prepaid plans offered by such corporations.

Whether Section 1 of the Sherman Act prohibits health service corporations from refusing to pay beneficiaries for covered dysfunctions based upon the health license of the health professional offering the treatment.

STATUTORY PROVISIONS INVOLVED

Section 1 Sherman Act
26 Stat. 209 (1890) as amended, 15 U.S.C. 1

Section 4 Clayton Act
38 Stat. 730 (1914) as amended, 15 U.S.C. 15 RCW 48.44.010(3)

STATEMENT OF THE CASE

The facts of this case are not in dispute. The defendants are organized as prepaid health service contractors organized under the laws of the State of Washington. Under RCW 48.44.010 a Health Care Service Contractor is a corporation sponsored by or intimately connected with a group of doctors licensed by the State of Washington and a participant is a health professional who has contracted with a health service contractor to accept payment from and to look solely to such contractor to accept payment from and to look solely to such contractor according to

the terms of the subscriber contract for any health care services rendered to a person who has previously paid such contractor for such services.

In this case the particular respondents are Pierce County Medical Bureau, Thurston County Medical Bureau, Cowlitz County Medical Service, Kitsap County Physician Service and Washington Physician Service. The purposes and operations of the bureaus are best described by the Pierce County Medical Bureau Manual which states in part:

PIERCE COUNTY MEDICAL BUREAU, INC.
HISTORY AND ORGANIZATION

> The Medical Service Bureaus in the State of Washington were organized originally in each locality by the County Medical Society of that locality. In each case, business operations were subsequently separated from the professional societies. Business managers were hired to assure successful operation.
>
> To assure fiscal stability for the fledgling corporations, participating physicians agreed to accept the payment they received from the corporation as payment in full for the services which they were to provide to subscribers contracting with the corporations.
>
> The physicians who founded them—and agreed to take the financial risks in the agreements which they signed—did so because they wanted:
>
> (1) To offer an alternative to closed panel, salaried physician arrangements which were developing in the Northwest;
>
> (2) To assure that their patients sought medical help when it was needed, without the barrier which the inability to pay might present;
>
> (3) To assure payment to the physicians for the services which they provide.
>
> There are 17 Medical Service Bureaus operating in the State. Each Bureau is incorporated under Washington laws and is operated by a locally elected Board of Trustees.

The bureaus operate on a cohesive system. Again a statement from the respondents in documents best describes the nature of the system:

The definition of a Statewide/WPS Contract is basically very simple. It pre-supposes a spirit of cooperative between participating Bureaus and Washington Physicians Service in determining the administrative method of handling multi-Bureau contracts that will provide the highest efficiency of operation at the minimum administrative cost. **It basically recognizes the autonomy of the Bureau as well as the coordinating role of Washington Physicians Service.** The designation of whether or not a contract is to be handled on a local Bureau control plan basis or a Washington Physicians SErvice basis should at all times recognize buyer demand, benefit structure development, percentage of participation of any one or group of Bureaus, the number of Bureaus to participate in the contract, and the geographic distribution of subscribers.

Of paramount consideration is the fact that the designation of whether a contract should be Bureau or Washington Physicians Service administered should be the subject of agreement between the parties involved. When it is agreed the contract shall be administered by Washington Physician Service, the participating Bureaus shall agree on the benefit structure, rating, retention, and all other administrative aspects of the contract. Heath Deposition Ex. 467 (Emphasis Added) (ER 101)

Further evidence of the bureaus' agreement not to compete appears in the Washington Physicians Service Bylaws.

ARTICLE XIII

Bureau Membership

Section 1. The Board of Directors shall have the authority to authorize the establishment of a local medical service bureau and define the area to be serviced by such bureau and authorize it to purchase shares of stock pursuant to Article II, Section 3, of the bylaws under the conditions . . .

XXX

Section 2. No more than one medical service bureau shall be authorized or recognized in a designated area. This shall

not apply to situations approved and existing at the time of the adoption of these bylaws.

Article XIV provides:

1. Each local medical service bureau shall have its service area fixed and determined by action of the Board of Directors of this corporation. Such service area shall be approved after consultation with the officers of local bureaus involved.

Article XIV states in its introduction:

It is further the intention and policy of the management of the affairs of this corporation to assist local medical service bureaus in perfecting efficient organizations and to act to coordinate local bureau activities and practices to the end that services offered and performed are maintained of uniform high quality to the end that all sections and localities and the qualified residents therein throughout the State may experience the value of the cooperative efforts of its members of the medical profession. It will be the purpose of the management to promulgate such business policies as it may consider appropriate to promote the offering of health care services on a pre-payment basis.

Article XIV further provides:

In the interest of securing uniformity of service throughout the service area and the State, the "Bureau Managers Association," comprised of chief executive officers of the several medical service bureaus is hereby designated as an advisory board to the officers and directors of this corporation. The Bureau Managers Association will report to the officers and directors their conclusion and recommendation on matters initiated by or referred to them.

and Article XIII provides:

ENFORCEMENT OF MEMBERSHIP STANDARDS

A review shall periodically be conducted regarding each Bureau's adherence to the Membership Standards by whatever means may be deemed appropriate.

Such review may include an on-site audit of the Bureau. A written report on the audit survey shall be submitted to such Bureau and to others as deemed appropriate.

Failure to meet Membership Standards by any one Bureau reflects on the well-being of all Bureaus and may be cause for termination of a Bureau's membership in Washington Physicians Service.

In addition, Washington Physicians Service publishes a unified list of providers which is introduced by the following statement:

WASHINGTON PHYSICIANS SERVICE

600 Fourth and Battery Building
Seattle, Washington 98121
(206) 682-9370

and the local Medical Bureaus

Members of groups covered by Washington Physicians Service will receive benefits when covered services are performed by a participating (member) physician or when the care is performed by a designated hospital.

This list includes over 6,000 physicians and surgeons—all members of their local Medical Bureau and Washington State Medical Association. There are approximately 100 designated hospitals listed. You may receive care from any of these participating physicians and designated hospitals.

A participating physician is defined as a licensed physician and surgeon (an M.D. or D.O.0) who has signed an agreement with a Medical Bureau to (a) bill the Bureau when covered services are provided and (b) accept the Bureau's payment as payment in full for those services.

The designated hospitals listed in this brochure are institutions that meet the requirements or license as General Hospitals in this State.

When you receive services, show your Washington Physicians Services ID card to your doctor or hospital. Participating physicians and designated hospitals will normally bill the Medical Bureau for you. There will be no claim forms for you to fill out. Ther Bureau will send its payment to the doctor or hospital.

If your physician's name is listed in this brochure, she or he was a participating physician at the time this list was published. However, your physician's membership status may have changed in the meantime. Check with her or him before receiving services. IT IS YOUR RESPONSIBILITY TO DETERMINE IF YOUR PHYSICIAN IS A PARTICIPATING PHYSICIAN.

The system is the largest supplier of prepaid health services in the State of Washington. Using 1980 figures, 25.7 percent of the state population, or 1,060,379 persons, was covered by the bureau system. The next largest supplier of prepaid health service was Blue Cross of Washington and Alaska with 17.7 percent, or 711,251 persons. The system received 333,031,863 dollars in premiums and paid 312,986,030 in claims. In fact, the system collected 28 percent of all premiums collected for all health care and accidents in the State of Washington and paid 30.5 percent of all claims for health and accidental reasons.

Using Pierce County alone the number of persons covered was 31 percent in 1980 which would indicate a higher market penetration in all categories than the state-wide coverage. In the period of 1981-1983 the percentage averaged by the bureau system declined as did the total number of covered persons due a rise in unemployment in the State of Washington. The relative position of the bureaus was substantially the same: 36.7 percent of the health care contractors in 1980 and 35.3 percent in 1982.

In evaluating these figures, it is clear that the uninsured part of the community would represent a much smaller part of the demand for health services than the insured part of the community and thus we can fairly assume that in 1980 state-wide the bureaus represented 30 percent of the market while Pierce County Medical represented 35 to 40 percent of the market.

The purpose of the bureaus as set out in their documents was to com-

pete with other health professionals for the custom of patients, to increase the demand for health services through the prepaid health service contract and to assure payment for services rendered.

As sensible economic actors the M.D.'s and D.O.'s wished to reserve all monies paid into the pre-paid health service contracts to themselves. Thus, except for services that they did not supply and were complementary to their own services such as ambulance or hospital services, no fee health services were paid out of the basic policies to other health professionals. An example of this exclusion is found in the Thurston County Medical Bureau contracts:

> Part II General Terms Defined
>
> 16. Participating Physicians
> A licensed doctor of medicine (M.D.) or osteopathy (D.O.) who has entered into a written agreement with the Bureau to render medical services stated in the agreement. A list of participating physicians is available from the Bureau.
>
> Part III
>
> 6. Participating Physicians
> No services or benefits are provided under this contract except while the beneficiary is under the regular care of a participating physician, except as otherwise specifically provided in this Part III, Paragraphs 7, 9 and 10. It shall be the beneficiary's responsibility to make sure that his doctor is a participating physician.

Further membership in the bureaus was limited to M.D.'s and D.O.'s. An example of such restriction is found in Art. III of the Pierce County Medical Bureau's Articles of Incorporation and Bylaws, and is as follows:

> Membership in this corporation shall be limited to persons who are regularly licenced and practicing physicians or surgeons, and members of the Medical Society of Pierce County. Other qualifications for membership and the rights of membership shall be as provided by the Bylaws of the corporation.

Qualification. No person shall become or remain a member of this corporation unless he shall be a member in good standing of the Medical Society of Pierce County.

In summary, what we have is a state-wide association of M.D.'s and D.O.'s which limit membership and status as participating physicians to M.D.'s and D.O.'s and exclude from membership and status other health professionals from competing for the custom of patients for services that M.D.'s and D.O.'s are licensed to perform. In addition, the bureaus act as insurance companies and sell policies for health services such as dental care or vision at an extra premium for services that M.D.'s or D.O.'s do not perform.

The issues in this case involve the exclusion of chiropractors from competing with M.D.'s and D.O.'s for services or treatment of dysfunctions of patients which petitioners as licensed health professionals are allowed to perform and the right of the beneficiary to such contracts to choose among health professionals for the delivery of such services or treatment.

It is clear that the dysfunction covered by the health services contract is the same service as defined by the health service contract. Thus Pierce County Medical Bureau Riders U and UU state this limitation as follows:

RIDER U

Benefits are provided for services performed by a licensed chiropractor if the service is within the lawful scope of the chiropractor's license and **if the group medical contract would have provided benefits for such service if it had been performed by a participating physician.** (Emphasis added)

RIDER UU

Benefits are provided for services performed by a licensed chiropractor if the service is within the lawful scope of the chiropractor's license and **if the group medical contract would have provided benefits for such service if it had been performed by a participating physician.** (Emphasis added)

These contracts contemplate that payment under a chiropractic rider is limited to services covered by the basic contract if performed by an M.D. or D.O. Thus, for example, a subscriber of a Pierce County Medical Bureau may go to an osteopath with a lower back complaint and be manipulated and have his total bill paid by respondent Pierce County Medical. On the other hand, if the same patient went to a petitioner chiropractor he would not be covered for the same service unless he paid an additional fee. Even if he paid the additional fee he would only be covered under the terms and limitations of the rider. Thus the subscriber would be required to pay twice for the same coverage if she wished to use a chiropractor instead of an osteopath, and the chiropractor would not receive full payment under the basic policy. In fact he could only receive a more limited payment under the rider.

The claim of the chiropractors in this lawsuit is simply to be admitted to membership and participation of the same terms and under the same rules that M.D.'s and D.O.'s are admitted to membership and participation and to subject to the same rules and risks as M.D.'s and D.O.'s. The claim of the subscribers is to have the same choice to pick the health professional for the treatment of covered dysfunctions among health professionals as the subscriber has to choose among M.D.'s and D.O.'s.

REASONS FOR GRANTING THE WRIT

The issues in this case relate to the misapplication by the Ninth Circuit Court of Appeals of the decision of *Blue Shield of Virginia v. McCready*, 457 U.S. 465, and the conflict between the Ninth Circuit's decision in this case and the decision of the Fourth Circuit in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (1980).

The Petitioners contend that neither of these cases can be properly distinguished from the facts of the case of the present petition.

In *Blue Shield of Virginia v. McCready*, 457 U.S. 465, a subscriber of a similar Blue Shield prepaid health contract sued to recover the amounts paid out of her own pocket to a Ph.D. psychologist who had treated her when she would have been covered by her contract if she had gone to a M.D. psychiatrist. This Court held that such a person had anti-trust standing to bring the action on the merits. In footnote form this Court quoted the decision of the Fourth Circuit Court of Appeals:

> The court found "that the Blue Shield Plans are combinations of physicians, operating under the direction and control of their physician members" Ibid.
>
> "Blue Shield Plans are not insurance companies, though they are, to a degree, insurers. Rather, they are generally characterized as prepaid health care plans, quantity purchasers of health care services. [I]n a real and legal sense, the Blue Shield Plans are agents of their member physicians" Id. at 480 citations and footnotes omitted.

In the same footnote, the Court went on to say:

> The Court of Appeals observed that psychologists and psychiatrists compete in the psycotherapy market, and that the decisions of Blue Shield "necessarily dictate, to some extent," who will be chosen to provide psychotherapy. Id. at 485. Finding the Blue Shield's policy of denying reimbursement for the psychotherapeutic services of psychologists unless billed through physicians, was not merely a cost containment device or simply "good medical practice" as claimed by Blue Shield, the court held that Blue Shield had violated the Sherman Act. Ibid.

The petitioners in this case are the chiropractors who were excluded from coverage under the basic policy in the same manner as the Ph.D. psychologists were excluded from coverage in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, supra.

The basis of that decision rests on two false premises. First, that there was no competitive injury and second, even if there was a competitive injury the offering of chiropractic services of an additional charge was a sufficient difference from the facts in *Virginia Academy* to distinguish that case from the present case.

The first statement by the Ninth Circuit Court of Appeals is clearly utter nonsense. The evidence before the Court was that each chiropractor in Pierce County would receive $10,000 more income per year if all persons who had basic coverage used chiropractors to the same extent as those who were required by law to have chiropractic coverage. These figures were derived directly from the experience relating to the

required public employee coverage. Since public employees were required to be covered, there would be no bias as to usage as might occur from using groups specially purchasing chiropractic coverage.

The answer of the Ninth Circuit Court of Appeals to this evidence is that no injury occurs because the purchasers may buy the service for a separate charge and, therefore, the decision not to buy the service must be a decision of the purchasers rather than of the medical bureaus. Such reasoning defies logic, especially as a method of distinguishing *McCready* and *Virginia Academy*.

In McCready, itself, the purchaser did in fact pay additional amount to receive the psychological services and it was clear that no one prevented the Ph.D. psychologists from offering their services directly to the subscriber or the employer for a separate and additional fee. Implicitly, the Ninth Circuit's argument rejects this Court's doctrine stated in *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), that the inclusion on less favored terms is as much a boycott as a complete exclusion.

As this analysis in the cases show, the Ninth Circuit Court of Appeals cannot properly distinguish either *McCready*, supra, or *Virginia Academy*. The only explanation for the Court's decision is that is finds that the complete exclusion from individual policies and the inclusion for an additional fee is a reasonable restraint or part of cost containment.

Under *NCAA v. Board of Regents of the University of Oklahoma*, ___ U.S. ___, 82 L.Ed.2d 70 (1984), the Court said:

> Per se rules are invoked when surrounding circumstances make the likelihood of anticompetitive conduct so great as to render unjustified further examination of the challenged conduct. But whether the ultimate finding is the product of a presumption or actual market analysis, the essential inquiry remains the same—whether or not the challenged restraint enhances competition. Under the Sherman Act the criterion to be used in judging the validity of a restraint on trade is its impact on competition.
>
> At the same time, the television plan eleiminates competitors from the market, since only those broadcasters able to

bid on television rights covering the entire NCAA can compete. Thus, as the District Court found, many telecasts that would occur in a competitive market are foreclosed by the NCAA's plan.

As a matter of law, the absence of proof of market power does not justify a naked restriction on price or output. To the contrary, when there is an agreement not to compete in terms of price or output, "no elaborate industry analysis is required to demonstrate the anti-competitive character of such an agreement." Petitioner does not quarrel with the District Court's finding that price and output are not responsive to demand. Thus the plan is inconsistent with the Sherman Act's command that price and supply be responsive to consumer preference. We have never required proof of market power in such a case. This naked restraint on price and output requires some competitive justification even in the absence of a detailed market analysis.

Thus, the NCAA television plan on its face constitutes a restraint upon the operation of a free market, and the findings of the District CCourt establish that it has operated to raise price and reduce output. Under the Rule of Reason, these hallmarks of anticompetitive behavior place upon petitioner a heavy burden of establishing an affirmative defense which competitively justifies this apparent deviation from the operations of a free market.

It is clear that even when the rule of reason applies to a boycott beacuse it involves a not-for-profit organization, the burden of proof as to the reasonableness of the restraint is on the party imposing the restraint rather than on the party injured by the restraint.

In this case, the bureaus and the Ninth Circuit Court of Appeals argue that the exclusion of chiropractors is justified on the basis of cost containment and consumer choice.

The Ninth Circuit on page five states, "Moreover, because plan purchasers are given a choice of coverage, an analysis of the relevant markets is necessary to determine whether the plan arrangement reduces 'the importance of consumer preference.' "

The reference to support this proposition is a self-serving study in a

medical journal. Certainly it did not relate to any proof put in by the respondents. In fact, it was clear during the discovery process that the respondents did not have any evidence to support cost containment and did not keep their records in such a manner as to determine whether there was any basis for such an assertion. If the view of the Ninth Circuit Court of Appeals is accepted, plaintiff would be required affirmatively to prove that his exclusion was not based upon cost containment when the records of the defendant were not kept in such a manner as to allow him to examine such data.

The only evidence before the trial court was the testimony of Larry Hansen of Cowlitz County Medical Service that there was no additional cost in covering chiropractors. It is clearly not in the interest of physician controlled organizations to allow other health providers to compete for the custom of the subscribers to the plan and, therefore, even if the other health providers such as nurse practitioners, podiatrists and chiropractors were more cost effective they would be rationally excluded in the interest of the members of the bureaus. In addition, the sales manager of respondent Washington Physician Service testified that the medical service bureaus would not allow other covered services such as gynecology, ear, nose and throat, and internal medicine to be sold separately. It is not surprising that the bureaus provide for separation of services by practitioner rather than by kind of service. Separation by practitioner would not lead to disputes within the medical profession. On the other hand, a separation by kind of illness covered would lead to disputes among the medical profession. Because of the self-interest of the members, the Ninth Circuit cannot give deference to the bureaus' decisions as independent business decisions because such health care contractors have a financial interest in preferring M.D.'s and D.O.'s over other health professionals.

The Ninth Circuit Court of Appeals clearly mischaracterizes the market control of the M.D.'s and D.O.'s and the bureaus. Because of State licensing, the M.D.'s and D.O.'s are the only health professionals that can deal with drugs and surgery and are absolutely essential to a comprehensive health package. Further, the medical bureaus are given a state tax advantage of commercial insurance companies, and lastly and most importantly the federal law makes dollars spent through employer-sponsored prepaid plans twice as valuable as other consumer dollars. Thus, if the M.D.'s and D.O.'s through medical bureaus can exclude other health professionals from the prepaid health market they

can assure their members an advantage of other health professionals where such health professionals compete directly with M.D.'s and D.O.'s. This is certainly the case in the competition between chiropractors, and M.D.'s and D.O.'s for the treatment for low back pain.

This Court's decision on whether to grant certiorari depends on the determination of whether the Ninth Circuit Court of Appeals was correct in disregarding this Court's determination in *McCready*, supra, and the Fourt Circuit decision in *Virginia Academy*.

The issue for this Court is whether M.D.'s and D.O.'s through medical bureaus may exclude health professionals as participants by license or whether they must have some rational basis for exclusion such as willingness to take risks, follow rules of treatment or pricing policies of the bureaus.

The economic analysis of the Ninth Circuit is equally faulty. The denial of the chiropractor of access to substantially a third of the insured medical market is clearly an economic injury. This Court could hardly deny that a rule by the medical bureaus excluding from membership or participation M.D.'s and D.O.'s until they had been established in a particular location for five years would injure such new physician in their trade or business.

The Ninth Circuit is equally wrong in its second proposition that there must be some justification for the additional charge or no one would purchase the additional coverage. The purchasers of prepaid group health insurance are not subscribers but the employers of the subscribers. The additional chiropractic coverage is only offered on group experience rate contract. The charge on experience rated contracts is based solely on the experience of the previous year. Thus, although the chiropractic coverage is billed separately the total payment may or may not be greater than a contract excluding chiropractic coverage. This is so that if persons who choose to go to chiropractors do not go to more expensive M.D.'s and D.O.'s. Under such circumstances there is no evidence whether the inclusion of chiropractic treatment increases the total costs of experienced rated contracts. The only evidence that exists on this matter indicates no additional costs. Additionally, the statement by the Ninth Circuit Court of Appeals on page four, "Unless it is presumed that these purchasers are acting irrationally, there must be some basic coverage and coverage with chiropractic benefits" is a complete non-sequitur. A prson might choose chiropractic at an additional cost

when the could obtain services from M.D.'s and D.O.'s because they believed that chiropractic treatment was more effective. On the other hand, if chiropractic was offered at no additional charge clearly all would choose chiropractic instead of none. The economic motivation to the price differentiation lies in the seller and not in the buyer's hands. The bureaus' motivation as representative of the M.D. is to deter the use of chiropractic services in competition with its members' services. Therefore, the presumption of reasonable business judgment granted by the Court of Appeals to the price differentiation is unjustified.

The last issue the Ninth Circuit Court of Appeals deals with is a supposed admission in petitioners' brief that an increase in health professionals included in a plan may increase the total costs of the plan. It is true that all other things being equal, a prepaid health plan offering a higher ratio of health providers to subscribers would have more usage than one that offered a lower ratio. The reason for this conclusion is obvious. First, there would be less waiting for services, and second, health professionals may take action to increase awareness of the need for services through advertising and personal contact.

An even more effective way of increasing cost is to offer first dollar coverage as the bureaus did from 1980-1984. Under first dollar coverage subscribers have no incentive to avoid medical care. Such coverage is beneficial to participating physicians but may raise the cost to the employers buying the services. Certainly, if cost containment is the issue the elimination of first dollar coverage is more effective method of controlling costs than the exclusion of other health professionals.

Since cost containment can be accomplished by limiting first dollar coverage or limiting the number of health professionals, the Ninth Circuit's decision that the exclusion of chiropractors as a cost containment measure is untenable when cost containment could be accomplished by more reasonable means such as by eliminating first dollar coverage and by a stricter application of rules concerning the appropriateness of medical care.

The reasonableness of a restraint must be judged on the basis that the end of restraint is accomplished with the least effect on competition possible. A gross discrimination based on license can not be justified on the basis that some cost saving might result. If that be the rule, the existing M.D. could restrain new M.D. entrants in the market by establishing a five year residence requirement in the name of cost saving.

CONCLUSION

If the decision of the Cout of Appeals for the Ninth Circuit is not reserved, this Court will have approved a radical restructuring of Anti-Trust law. This Court will have approved a doctrine that requires Plaintiffs to show as part of their affirmative case the unreasonableness of a boycott. Further, this Court will have approved a doctrine that requires Plaintiffs to show public injury. Lastly, this Court would approve the reversal of the cases of *Blue Shield of Virginia v. McCready, NCAA v. Board of Regents of the University of Oklahoma*, and *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, supra.

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UNITED STATES COURT OF APPEALS

for the

NINTH CIRCUIT

October Term, 1985

CHIROPRACTORS, JAMES A. LEONE and
JAMES A. LEONE, D.C., LTD., P.S., et al.,
Plaintiffs-Appellants,

vs.

PIERCE COUNTY MEDICAL BUREAU,
Defendants-Appellees.

Appeal from the United States District Court
for the Western District of Washington
Honorable Jack Tanner, District Judge, Presiding
Argued and submitted June 25, 1985—Seattle, Washington

Before: WALLACE, FARRIS, and HALL, Circuit Judges.

After discovery, the plaintiffs moved for partial summary judgment on the issue of liability. They asserted that the terms of the defendants' policies excluding them from the basic coverage established the defendants' liability and stipulated that they would introduce no further evidence on the issue at trial, so that, if the court found that liability was not established, dismissal was proper. The defendants made a cross-motion for dismissal or summary judgment and accepted the plaintiffs'

factual assertions for purposes of their motion. The district court granted the defendants' motion to dismiss because the plaintiffs had failed to demonstrate any competitive injury. The plaintiffs appeal. We affirm.

The defendant medical-bureaus were formed to compete with closed-panel health maintenance organizations and to stimulate the demand for health services. Doctors and health professionals associated with the bureaus agree to accept prepayment in consideration for services provided for subscribers. Certain activities of the various medical bureaus are coordinated on a statewide basis by the defendant Washington Physicians Service.

Coverage for chiropractic treatment is not offered as part of the basic policy. It is available as an optional rider for an additional premium. Under this rider, benefits for chiropractic services are limited to treatment that would have been covered by the basic group medical contract "if it had been performed by a participating physician." All contracts for state employees are required to include chiropractic service. A few private employers and other groups have also chosen chiropractic coverage.

STANDARD OF REVIEW

Because the plaintiffs stipulated that the evidence they presented in support of their partial summary judgment motion included everything they would present at trial, the district court concluded that they should be treated as having "put on their case at trial and rested." Accordingly, the court treated the defendants' motion for dismissal or summary judgment as the equivalent of a motion for directed verdict. Even under the more lenient standard applicable to summary judgments, dismissal was proper.

Summary judgment is properly used "to dispose of antitrust complaints that lack any significant supporting evidence." *Klamath-Lake Pharmaceutical Assn. v. Klamath Medical Serv. Bureau*, 701 F.3d 1276, 1282 (9th Cir.), *cert. denied*, 104 S. Ct. 88 (1983). We review grants of summary judgment *de novo*. *ILGW v. Sureck*, 681 F.2d 624, 628–29 (9th Cir. 1982) *rev'd on other grounds sub nom. INS v. Delgado* 104 S. Ct. 1758 (1984). We must affirm the grant of summary judgment if, viewing all of the evidence and inferences in the light most favorable to the plaintiffs, "there are no genuine issues of material fact and that the [defendants are] entitled to prevail as a matter of law." *Id.*

DISCUSSION

Characterizing the defendant bureaus as horizontal combinations of competitors—physicians and doctors of osteopathy—organized to exclude direct competition from chiropractors, the plaintiffs assert that such combinations are *per se* violations of the Sherman Act. The Supreme Court recently indicated that "a plaintiff seeking application of the *per se* rule" to an alleged boycott must show that it "falls into a category likely to have predominantly anticompetitive effects." *Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co.*, 105 S. Ct. 2613, 53 U.S.L.W. 4733, 4737 (U.S. June 11, 1985) (No. 83-1368). That case involved a challenge to an expulsion from a joint venture. The Court held that application of the *per se* rule was improper because the plaintiff had not shown that the defendant joint venture "possesses market power or unique access to a business element necessary for effective competition." *Id.* In the present case, the chiropractors also fail to show that the bureaus possess market power or control a necessary competitive element. Application of the *per se* rule is, therefore, unwarranted.

Moreover, regardless of whether the bureaus' activity is analyzed under the *per se* rule or the rule of reason, it remains incumbent upon the plaintiffs to show that they suffered competitive injury as a result of that activity: "Causal antitrust injury is an essential element of any remedy under the Sherman Act." *Northwest Publications, Inc. v. Crumb*, 752 F.2d 473, 476 (9th Cir. 1985) (applying requirement of injury to case involving *per se* illegal price-fixing). The plaintiffs incorrectly assumed that the mere allegation of a concerted refusal to deal by the bureaus established their claim.

Purchasers of plan coverage are given a choice of whether to purchase chiropractic benefits. All state contracts must include chiropractic benefits and a number of private purchasers have also opted for such coverage. Unless it is presumed that these purchasers are acting irrationally, there must be some economic justification for the price-differential between basic coverage and coverage with chiropractic benefits. Otherwise, no purchase would opt for coverage with chiropractic benefits.

The plaintiffs, in fact, admit that an increase in the number of health professionals under a given plan will increase the cost of providing service. Without any economic data on what costs the inclusion of chiropractors would involve, it is impossible to say that the defendants'

policy is a restraint of trade and not a recognition of economic realities. See Kissam, *Antitrust Law and Professional Behavior*, 62 Tex. L. Rev. 1, 39 (1983) (inclusion of chiropractors under Blue Shield plans may involve significant costs and reduce competition in the health care-provider market). Moreover, because plan purchasers are given a choice of coverage, an analysis of the relevant markets is necessary to determine whether the plan arrangement reduces "the importance of consumer preference." *Cf. NCAA v. Board of Regents of the University of Oklahoma*, 104 S. Ct. 2948, 2964 (1984) (condemning arrangements having that effect). The plaintiffs recognize that a demonstration of the defendants' market power is essential to their case yet they fail to present any evidence on this issue.

The defendants' plans cover only a small percentage—20% to 30%—of the health care markets in Washington and that percentage has been declining. They also face competition from closed-panel or HMO plans. Finally, a substantial portion of the defendants' plans do provide for chiropractic benefits. Without significant market power, any attempt by the defendants to foist unreasonable fees upon plan purchasers desiring chiropractic benefits would simply drive those purchasers to deal with other health care providers. The evidence indicates, however, that several purchasers have chosen the chiropractic benefits with the additional premium. The plaintiffs have failed to establish any competitive injury. The evidence they presented on their projected business losses is irrelevant; competitive injury to the market is the significant consideration. *Klamath-Lake*, 701 F.2d at 1292; *see also Crumb*, 752 F.2d at 476-77 (plaintiffs losses were the result of competitive market forces rather than challenged price-fixing clauses).

The choice of benefits offered to plan purchasers distinguishes *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), on which the plaintiffs rely for support. In that case, there existed an absolute prohibition on the inclusion of benefits for psychologist treatment. Reimbursement was available for psychologist treatment if it was billed through a plan physician, but plan purchasers—who are the significant economic actors in the market for health services—were offered no choice regarding the direct inclusion of psychologist benefits for their subscribers. In *Blue Shield of Virginia*, no choice of benefits was offered and consumer preferences and the natural market forces were, accordingly, stymied. In the present case, plan purchasers are offered a

choice and several have exercised the option for chiropractic benefits. In the absence of a market analysis, a trier of fact could not conclude that this situation does not represent a competitive market. *Cf. Id.* at 485 (defendants had significant market power).

AFFIRMED.

(Recess)

THE COURT: I assume that you have made your closing argument, Mr. Rudolph, all right. If I understand it now, this court is to rule on whether or not the plaintiff has made a prima facie case at the end of their case and having rested. I think the test that the court must use is is the evidence sufficient, viewed in the light most favorable to the non-moving party, that any rational trier of the facts could find that the essential elements have been shown by a preponderance of the evidence. Isn't that the test? I think so.

Well, the statute provides, reading from 15 United States Code annotated Section 1, that every contract, combination in the form of trust or otherwise, or conspiracy . . . So I think the plaintiff is right that a conspiracy in itself does not have to be one of the necessary elements, but it can be.

The other element, there must be a restraint in trade and it must be unreasonable and then it must then inhere to damage of the plaintiffs. In reading from a Supreme Court case, in National Society of Professional Engineers v. United States, at 435 U.S. 679 at 692, a 1978 case, that a conclusion that a restraint of trade is unreasonable may be based either, one, on the nature or character of the contract or two, on the surrounding circumstances giving rise to the inference or presumption that they intended to restrain trade and enhance prices. Under either branch of the test, the inquiry is confined to a consideration of impact upon competitive conditions.

I can't find any evidence of that as it is now before me. So the conclusion of the court is to grant the defendant's summary—no, not summary. I don't want to get that—motion to dismiss for failure to prove a prima facie case, that the elements have not been show by a preponderance of the evidence.

You want to submit the order? If you want to get together on the order so you have an appealable order.

SHERMAN ACT[1]

§1. Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.[2] Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.[3]

§2. Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

1. 26 Stat. 209 (1890), as amended, 15 U.S.C.A. §§1-7 (1980).

2. Amendments in 1975, 89 Stat. 801, repealed the 1937 amendments, 50 Stat. 693, which had immunized from federal antitrust law those resale price maintenance arrangements permitted by state law. The 1937 legislation had attached two provisos to the first sentence of §1: "*Provided*, That nothing herein contained shall render illegal, contracts or agreements prescribing minimum prices for the resale of a commodity which bears, or the label or container of which bears the trademark, brand, or name of the producer or distributor of such commodity and which is in free and open competition with commodities of the same general class produced or distributed by others, when contracts or agreements of that description are lawful as applied to intrastate transactions, under any statute, law, or public policy now or hereafter in effect in any State, Territory, or the District of Columbia in which such resale is to be made, or to which the commodity is to be transported for such resale, and the making of such contracts or agreements shall not be an unfair method of competition under section 5, as amended and supplemented, of the act entitled "An Act to create a Federal Trade Commission, to define its powers and duties, and for other purposes," approved September 26, 1914; *Provided further*, That the preceding proviso shall not make lawful any contract or agreement, providing for the establishment or maintenance of minimum resale prices on any commodity herein involved, between manufacturers, or between producers, or between wholesalers, or between brokers, or between factors, or between retailers, or between persons, firms, or corporations in competition with each other."

3. The penalty provisions in §§1-3 were substantially changed in 1974, 88 Stat. 1708. Until then, violations were misdemeanors, without distinction between individuals and corporations, and with a maximum fine of $50,000 (increased from $5000 in 1955, 69 Stat. 282) and maximum imprisonment of one year.

CLAYTON ACT[1]

§1. (a) "Antitrust laws," as used herein, includes the Act entitled "An Act to protect trade and commerce against unlawful restraints and monopolies," approved July second, eighteen hundred and ninety;[2] sections seventy-three to seventy-seven, inclusive, of an Act entitled "An Act to reduce taxation, to provide revenue for the Government, and for other purposes," of August twenty-seventh, eighteen hundred and ninety-four;[3] an Act entitled "An Act to amend sections seventy-three and seventy-six of the Act of August twenty-seventh, eighteen hundred and ninety-four, entitled 'An Act to reduce taxation, to provide revenue for the Government, and for other purposes,'" approved February twelfth, nineteen hundred and thirteen;[4] and also this Act.

"Commerce," as used herein, means trade or commerce among the several States and with foreign nations, or between the District of Columbia or any Territory of the United States and any State, Territory or foreign nation, or between any insular possessions or other places under the jurisdiction of the United States, or between any such possession or place and any State or Territory of the United States or the District of Columbia or any foreign nation, or within the District of Columbia or any Territory or any insular possession or other place under the jurisdiction of the United States: *Provided,* That nothing in this Act contained shall apply to the Philippine Islands.

The word "person" or "persons" wherever used in this Act shall be deemed to include corporations and associations existing under or authorized by the laws of either the United States, the laws of any of the Territories, the laws of any State, or the laws of any foreign country.

(b) This Act may be cited as the "Clayton Act."

1. 38 Stat. 730 (1914), as amended, 15 U.S.C.A. §§12-27 (1980). As originally enacted, each Clayton Act section began with the word "that," which is omitted here. Modern amendments abandoned that practice.

2. The Sherman Act.

3. These were the Wilson Tariff Act's antitrust amendments. 28 Stat. 570 (1894), as amended, 15 U.S.C.A. §§8-11 (1977). These provisions forbid combinations or contracts in restraint of import trade.

4. 37 Stat. 667 (1913), 15 U.S.C.A. §§8, 11 (1977).

§4.[6] Any person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws may sue therefor in any district court of the United States in the district in which the defendant resides or is found or has an agent, without respect to the amount in controversy, and shall recover threefold the damages by him sustained, and the cost of suit, including a reasonable attorney's fee. . . .

6. Sections 4A and 4B were added by 69 Stat. 282-283 (1955), which also made conforming amendments to §5 and added the proviso to current §5(i). Sections 4C-4H were added by 90 Stat. 1394-1396 (1976). 94 Stat. 1159 (1980) added to §§4, 4A, and 4C(a)(2) permission for the court to award interest on its judgment for all or any part of the period between the filing of the complaint and the date of the judgment if "just in the circumstances." To make that determination, the court is to consider only whether either party (1) offered motions, claims, or defenses "so lacking in merit" as to show an intentional delay or bad faith, (2) violated any rule or order concerning expeditious proceedings, or (3) acted "primarily for the purpose of delaying the litigation or increasing" its cost. A fourth element is to be considered under §4A: whether prejudgment interest is necessary to compensate the United States for its injury.

48.44.010. Definitions

For the purposes of this chapter:

(1) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital and other therapeutic services. Ambulance services licensed in this state, the services of an optometrist licensed by the state of Washington, the services of a podiatrist licensed by the state of Washington, and the services of a pharmacist registered by the state of Washington are also declared to be health care services for the purposes of this chapter.

(2) "Doctor" means any person lawfully licensed or authorized to render any health care services.

(3) "Health care service contractor" means any corporation, cooperative group, or association, which corporation, cooperative group, or association is sponsored by or otherwise intimately connected with a group of doctors licensed by the state of Washington or by a group of hospitals licensed by the state of Washington; or doctor licensed by the state of Washington; or group of doctors licensed by the state of Washington, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. The term also includes any corporation, cooperative group, or association, sponsored by or otherwise intimately connected with a group of pharmacists registered by the state of Washington; or any pharmacist, or group of pharmacists, registered by the state of Washington; who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.

(4) "Participant" means a doctor, hospital, or licensed pharmacy, drug store or dispensary, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid such contractor for such services.

Enacted by Laws 1947, ch. 268, § 1. Amended by Laws 1961, ch. 197, § 1; Laws 1965, ch. 87, § 1; Laws 1980, ch. 102, § 10; Laws 1983, ch. 154, § 3; Laws 1983, ch. 286, § 3.

Petitioners

JAMES A. LEONE and JAMES A. LEONE, D.C. LTD. P.S.; DONALD S. PADDOCK; JAMES T. OVERLAND; RONALD E. SOIBERG, TERRY E. SWARTLING; PHILLIP M. PADELFORD and ALPINE CHIROPRACTIC CENTER P.S.; RICHARD D. LEONE and RICHARD D. LEONE CHIROPRACTIC CENTER, P.S.; ROBERT G. BANGS and ROBERT G. BANGS, D.C., P.S.; JEFFREY A. FINNIGAN; JOSEPH T. McEACHRON; DENNIS B. ROYAL and OLYMPIA CHIROPRACTIC CENTER, P.S.; JAMES L. GOULD and GOULD CHIROPRACTIC CENTER, P.S.; LEAMON C. SANDIFER and SANDIFER CHIROPRACTIC OFFICE, INC., P.S.; DANIEL T. HANSEN; K. R. STILLWELL, R. H. STILLWELL and STILL-WELL CHIROPRACTIC CLINIC INC. PC; WILLIAM B. BRUTON; ELEANOR L. M. DUBEY; KENNETH I. RASMUSSEN and DOROTHY RASMUSSEN; WADE K. RANDALL; JAMES G. VICTOR; THOMAS L. MOLZAN; and C. J. BARTNESS and C. J. BARTNESS, D.C., INC., P.S.

Respondents

PIERCE COUNTY MEDICAL BUREAU, THURSTON COUNTY MEDICAL BUREAU, COWLITZ MEDICAL SERVICE, KITSAP PHYSICIANS SERVICE, and WASHINGTON PHYSICIANS SERVICE.